The Right to Health and the Post-2015 Health and Sustainable Development Goal Agenda

Jonathan Mann's 1997 Call for a Paradigm Shift Remains Imperative

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1. INTRODUCTION

The Emerging Fields Initiative (EFI) Conference, »The right to health – an empty promise?«, held 14–16 September 2015 in Berlin, Germany, occurred one week before the General Assembly gathered together at United Nations (UN) headquarters in New York to vote on the post-2015 Sustainable Development Goal (SDG) agenda. At that high-level General Assembly plenary meeting, the »UN Sustainable Development Summit« of 25–27 September 2015, the UN member states collectively endorsed the General Assembly resolution, »Transforming our World: the 2030 Agenda for Sustainable Development«.[1] This formative UN resolution on the post – 2015 SDG agenda will be the global community's blueprint for development – the »plan of action for people, planet and prosperity«[2] – for the next 15 years. Consisting of a 35-page, 91-paragraph document, this important

1 A/Res/70/1, 25 September 2015.

2 Ibid.

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resolution contains much of the »unfinished business« of its precursor, the Millennium Development Goal (MDG) agenda.

Expiring on 31 December 2015, the eight MDGs were originally introduced to the world by former UN Secretary-General Kofi Annan in his »Road map towards the implementation of the UN Millennium Declaration report« (Road map report) of September 2001.[3] Indeed, the MDGs have been described as the new global »super-norm« for poverty reduction.[4] Much has been written on their rise, their benefits and deficits – including a myriad of critiques by global health analysts. Notwithstanding these, the MDGs *have* played a historic and transformative role in streamlining global attention, resource, and programmatic action onto three health and development priorities: the reduction of child mortality (MDG 4); the improvement of maternal health (MDG 5); and combatting HIV/AIDS, malaria and other diseases (MDG 6).

The 17 SDGs outlined in the September 2015 resolution extend the MDG agenda.[5] This is mainly because the UN resolution on the post-2015 SDGs shifts the world's development focus from poverty eradication (as emphasised by the MDGs) to poverty eradication *and* sustainable development, while also reinforcing the inclusive nature of the new goals through its central principle, »that no one will be left behind«.[6] Of added significance, the post-2015 agenda is a »new Universal Agenda«;[7] applicable to all, everywhere, in low-, middle- and high-income countries alike. As para. 5 of the post-2015 UN resolution powerfully states:

»This is an Agenda of unprecedented scope and significance. It is accepted by all countries and is applicable to all, taking into account different national realities, capacities and levels of development and respecting national policies and priorities. These are universal goals and targets which involve the entire world, developed and

3 Annan (2001).

4 Fukuda-Parr/Hulme (2009).

5 Full list of the 17 SDGs under http://www.un.org/sustainabledevelopment/sustainabledevelopment-goals/ [24.02.2017].

6 Brolan (2016).

7 A/Res/70/1, 25 September 2015.

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developing countries alike. They are integrated and indivisible and balance the three dimensions of sustainable development.«[8]

Global health was represented in the 17 SDGs in a single goal, *SDG 3: Ensure healthy lives and promote well-being for all at all ages* (table 1). While health was prominently featured in three of the eight MDGs (MDGs 4–6), the lone post-2015 global health and development goal, SDG 3, is no less »a win« for post-2015 health advocates. This is because SDG 3 and its nine targets and four means of implementation not only progress the unfinished business of the MDG health agenda through SDGs 3.1–3.3, but considerably expand this agenda to also include global prioritisation of non-communicable diseases (SDG 3.4), the achievement of Universal Health Coverage (SDG 3.8) that explicitly includes universal access to sexual and reproductive healthcare services (SDG 3.7), the prevention and treatment of substance abuse (SDG 3.5), and reduction of global morbidity and mortality due to road traffic accidents (SDG 3.6) as well as poor ecological and environmental health (SDG 3.9).

Table 1: Post-2015 global health and development goal (SDG 3)

Goal 3. Ensure healthy lives and promote well-being for all at all ages
Targets **3.1** By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births **3.2** By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births

8 UN General Assembly (2015a).

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3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases

3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being

3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents

3.7 By 2030, ensure universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

3.8 Achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all

3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination

Means of Implementation

3.a Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate

3.b Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect

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developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all

3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States

3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

Source:http://www.un.org/sustainabledevelopment/sustainabledevelopm ent-goals/ [24.02.2017]

What is curious about the content of SDG 3, however, is that despite the UN member states having ratified one or more binding treaties that include »the right of everyone to the enjoyment of the highest attainable standard of physical and mental health« (the right to health),[9] and this right otherwise expressed in over 100 national constitutions,[10] these same countries in September 2015 unanimously voted for a single health goal *bereft of clear and cogent* right to health language. In other words, SDG 3 did not explicitly contain or reference the right to health originally introduced in the World Health Organization's constitution in 1946 and then codified in international law particularly by way of Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) of 1966. Since that time, the right to health has been recognised in a wide array of other international and regional human rights instruments.[11]

Yet if the right to health in international law is the normative gold standard for global health that *all* UN member states have adopted (in some

9 Backman et al. (2008).

10 Kinney/Clark (2004); Perehudoff (2008).

11 E/C.12/2000/4, 11 August 2000.

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form) to respect, protect and fulfil, it is only right to ask *why* this human right did not translate into the overarching post-2015 global health umbrella goal, or was not sewn into one of the nine targets or, at very least, one of SDG 3's four means of implementation. In fact, close inspection of the content of the 17 SDGs and their 169 associated targets and means of implementation contained between pages 14 to 27 of the UN General Assembly resolution on the post-2015 SDG agenda highlights human rights' marginal presence. For instance, human rights' shortened version, »rights«, is explicitly found in six locations in the SDG metrics framework: in four targets and two means of implementation (Table 2). This ensures »rights« are expressed in only five of the 17 goals; less than a third of the SDGs. Further, where »rights« are referred to as »human rights« in the one standalone target, Target 4.7 (see Table 2), this phrase is inserted to affirm that the learning of human rights in educational settings is to be promoted. Of course, the learning and generation of human rights awareness is important; but in many ways this alone is insufficient to adequately and incrementally achieve the larger human right to education.[12]

Table 2: Rights in the post-2015 SDG framework

Post-2015 Goal	Target	Means of Implementation
Goal 1: End poverty in all its forms everywhere	**1.4:** By 2030, ensure that all men and women, in particular the poor and the vulnerable, have *equal rights* to economic resources, as well as access to basic services, ownership and control over land and other forms of property, inheritance, natural resources, appropriate new	

12 Unterhalter (2014).

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	technology and financial services, including microfinance.	
Goal 3: Ensure healthy lives and promote wellbeing for all at all ages		**3.b** Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms *the right of developing countries* to use to the full the provisions in the *Agreement on Trade-Related Aspects of Intellectual Property Rights* regarding flexibilities to protect public health, and, in particular, provide access to medicines.
Goal 4: Ensure inclusive and equitable quality education and promote lifelong learning	**4.7:** By 2030, ensure that all learners acquire the knowledge and skills needed to promote sustainable development and	

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opportunities for all	sustainable lifestyles, *human rights*, gender equality, promotion of a culture of peace and non-violence, global citizenship and appreciation of cultural diversity and of culture's contribution to sustainable development.	
Goal 5: Achieve gender equality and empower all women and girls	**5.6:** *Ensure universal access to sexual and reproductive health and reproductive rights* as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.	**5.a** Undertake reforms to give women *equal rights to economic resources*, as well as access to ownership and control over land and other forms of property, financial services, inheritance and natural resources, in accordance with national laws.
Goal 8: Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all	**8.8:** *Protect labour rights* and promote safe and secure working environments for all workers, including migrant workers in particular women migrants, and those in precarious employment.	

Source: Brolan (2016)

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But there is an alternative argument that could be mounted that would submit the post-2015 SDG metrics framework *is*, or *presents* or *is founded upon*, a veritable human rights agenda. This is in light of the UN General Assembly's emphasis in the post-2015 outcome document's preamble and declaration on the interconnect between international human rights law and the post-2015 development action plan. This is notably expressed in both the content of the UN resolution's preamble and in paras. 8, 10, 19 and 20. Indeed, the post-2015 declaration envisages a world »of universal respect for human rights and human dignity, the rule of law, justice, equality and non-discrimination«.[13] It outlines the new SDG agenda as:

> »[g]uided by the purposes and principles of the Charter of the UN, including full respect for international law. It is grounded in the Universal Declaration of Human Rights, international human rights treaties, the Millennium Declaration and the 2005 World Summit Outcome. It is informed by other instruments such as the Declaration of the Right to Development.«[14]

Despite such strong rhetoric for the integration of international human rights law in the post-2015 development goal agenda, in many respects these words on paper must be approached with caution. This is because, and if over ten years of MDG implementation by the global community is the litmus test, it is likely member state (and their development partners) focus will narrow to fixate on implementation of the SDG metrics framework; on achieving the 17 goals, their associated targets and means of implementation, and country-specific indicators *only*. This aligns with the potent adage in international development circles – ›what gets measured gets done‹ – and human rights are conspicuously absent from the language of SDG measurement. This includes not only the right to health in its express form, but also sexual and reproductive health and rights (SRHR).

It follows that SRHR as sexual and reproductive health *and rights* did not survive the political sieve of post-2015 negotiations. While access to universal sexual and reproductive healthcare services is sought to be achieved in SDG 3.7, this is not coherently framed as a matter of SRHR.

13 A/Res/70/1, 25 September 2015.

14 Ibid., para. 10.

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Furthermore, although Target 6 of SDG 5, »Achieve gender equality and empower all women and girls«, appears laudable in its aim,

»[to] [e]nsure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population Development and the Beijing Platform for Action and the outcome documents of their review conferences«,[15]

when the text is in fact examined in its minutiae it is evident SDG 5.6 is paradoxical, claiming these rights but implicitly diminishing them. SDG 5.6 cannot be »in accordance with the Programme of Action of the International Conference on Population Development […]« as that document states sexual health is *unequivocally* part of reproductive health rights, whereas SDG 5.6 cleverly *splits* SRHR into »sexual and reproductive health *and reproductive rights«*.

This chapter will consequently examine potential reasons why the express right to health – including SRHR – did not translate into the headline post-2015 global health goal for health, *SDG 3: Ensure healthy lives and promote well-being for all at all ages*, nor explicitly form part of the content of SDG 3's nine targets and four means of implementation.[16]

This chapter will now turn to examine the key post-2015 reports that informed the post-2015 SDG decision-making landscape and whether the right to health was explicitly present in SDG metrics proposals (i.e. the goals, targets and indicators). Six reasons as to why the right to health appeared marginal in emergent high-level post-2015 negotiations will be examined. This will be followed by reflection on *what this all means* for right to health advocates in a post-2015 world. By thinking about the future we

15 A/Res/70/1, 25 September 2015, SDG 5.6, 18.

16 This chapter's exploration will be based on the presentation at the EFI Conference in Berlin in September 2015, *»Everywhere but not specifically somewhere«: Why is the right to health not explicit in post-2015 negotiations? A Qualitative Study*. This presentation itself was grounded on the content of a peer-reviewed paper of the same name published in the scientific-journal, *BMC International Health and Human Rights* in 2015, co-authored by Dr. Claire E. Brolan, Dr. Peter S. Hill and Dr. Gorik Ooms, cf. Brolan et al. (2015).

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will then return to the past, and allow Jonathan Mann's inspirational words to echo through to the present.

2. BACKGROUND TO THE FORMULATION OF THE SINGLE POST-2015 HEALTH GOAL

Despite activism encouraging a right to health goal, particularly driven by the post-2015 Go4Health research consortium (among others),[17] an explicit post-2015 health rights narrative did not gain effective traction in key post-2015 health goal proposals. Here, reference is made to four post-2015 goal proposals in particular, which incrementally emerged from UN-initiated and intergovernmental post-2015 forums. The first was the outcome report of April 2013 of the post-2015 Global Thematic Consultation on Health.[18] This report synthesised the vast input into the post-2015 Global Thematic Consultation on Health (one of eleven global thematic consultations overseen by the UN Development Group) held between September 2012 and March 2013, and co-ordinated by UNICEF and the WHO with support from the governments of Sweden and Botswana. The consultation's objective was threefold: to stimulate broad discussion at all levels (global, regional, national) on MDG progress and lessons learnt from the health MDGs; to develop a shared understanding among key stakeholders (member states, UN agencies, civil society, and others) on health's positioning in the post-2015 development framework; and to propose health goals and associated targets and indicators for the post-2015 development agenda. The post-2015 Global Thematic Consultation on Health was far-reaching and included 14 international meetings drawing over 1,600 people, submission of over 100 papers by an array of authors and organizations, as well as attracting more than 150,000 people to its respective website.

The post-2015 Global Thematic Consultation on Health culminated in a High-Level meeting in Botswana in early March 2013 to flesh out the content of the post-2015 Global Thematic Consultation on Health's final synthesis report. This latter document, released in April 2013, proposed one

17 Ooms et al. (2013).

18 UN System Task Team (2013).

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post-2015 health and development goal – »Maximising Healthy Lives« – with three underlying interventions: accelerate the MDG agenda, reduce the non-communicable disease burden; and ensure Universal Health Coverage and access.[19] The following month, May 2013, the second key post-2015 health goal proposal was released by the UN's post-2015 High-Level Panel of Eminent Persons on the Post-2015 Development Agenda (High-Level Panel), which was originally launched by UN Secretary-General Ban Ki-moon in July 2012 and co-chaired by the Presidents of Liberia and Indonesia, and the Prime-Minister of the United Kingdom.[20] Similar to the post-2015 Global Thematic Consultation on Health's April 2013 report, the High-Level Panel presented one »illustrative« global health goal to the world, Goal 4: Ensure Healthy Lives, with five targets, which also included the unfinished business of the MDG health agenda, as well as reducing the disease burden of »priority« non-communicable diseases and neglected tropical diseases. In a departure from the post-2015 Global Thematic Consultation on Health, Universal Health Coverage was not identified by the High-Level Panel as an express target, though ensuring SRHR was. The right to health was not proposed in either report as a (or the) post-2015 headline health goal, nor progressive achievement of the right to health as an underlying global health goal target.

A week after the High-Level Panel released its report, in June 2013 another report proposing a framework for the post-2015 development agenda was offered by the Sustainable Development Solutions Network led by Professor Jeffrey Sachs. Similar to the High-Level Panel, UN Secretary-General Ban Ki-moon also launched the Sustainable Development Solutions Network in August 2012, which comprised scientific and technical expertise from academia and non-UN agencies. In contrast to the High-Level Panel's twelve illustrative goals, the Sustainable Development Solutions Network suggested ten sustainable development priorities, the fifth of which was for global health (Goal 5: Achieve Health and Wellbeing at All Ages).[21] Again, no express mention of progressively achieving the right to

19 UN System Task Team (2013).

20 UN Secretary-General's High-Level Panel of Eminent Persons on the Post-2015 Development Agenda (High-Level Panel) (2013).

21 Sustainable Development Solutions Network (2013).

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health as a possible headline post-2015 global health goal, or underlying target, was made.

Following the release of these three post-2015 reports between May and June 2013, leadership of the post-MDG discussion formally shifted from UN to member state auspice. This shift had already begun in early 2013 when the UN General Assembly proclaimed that Rio+20 Conference's Open Working Group would transform into the »Open Working Group on the Sustainable Development Goals«.[22] In May-June 2014, the Open Working Group proposed a »zero draft« of 17 SDGs to be attained by the year 2030, with the proposed global health goal, SDG 3: Attain healthy life for all at all ages, with nine associated targets.[23] The Open Working Group's final SDG proposal was then released over twelve months later in August 2015 in a draft UN General Assembly resolution.[24]

It was the content of this draft resolution that was finally voted on by UN member states at the September 2015 high-level summit in New York, where UN member states unanimously endorsed the draft resolution's content of 17 SDGs and 169 targets and means of implementation.[25] However, the global health goal's content had altered from the Open Working Group's mid-2014 proposal: now, the global health SDG was titled, »Ensure health lives and promote well-being for all at all ages«. Thus the goal's language had changed from attaining *to ensuring* healthy lives and the promotion of well-being for all at all ages. Nine targets and four means of implementation were now incorporated (again, see Figure 2). When these nine targets and four means of implementation are placed under the normative-legal analytic microscope, the right to health in its express form appears absent.

22 A/67/L.48/Rev.1, 15 January 2013.

23 Open Working Group for Sustainable Development Goals (2014).

24 A/69/L.85, 12 August 2015.

25 A/Res/70/1, 25 September 2015.

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3. WHY THE RIGHT TO HEALTH WAS NOT EXPLICIT IN THE FINAL POST-2015 HEALTH GOAL (SDG 3)

The *BMC International Health and Human Rights* article, upon which the EFI conference presentation was based, provides six reasons that may explain the right to health's marginalisation from the final post-2015 health and development goal framework.[26] These reasons have an empirical base: they are founded on interview data collected in 2013 and 2014 by members of the Go4Health research team on the right to health's location in the unfolding post-2015 health goal negotiations. The team from the School of Public Health at The University of Queensland (Dr. Claire E. Brolan and Dr. Peter S. Hill), over a two year period, interviewed key informants from the multilaterals and inter-related agencies responsible for health in the post-2015 SDG agenda (or the formulation of the SDG agenda more broadly), whom were mainly based in New York, Washington DC, Paris and Geneva.[27] Key informants frequently sat at the interface of UN and member state, as well as civil society, post-2015 discussion. Applying qualitative analytic techniques and aided by NVIVO 9 software, the interview data was subject to a discourse analysis and thematic analysis. The methodology is detailed not only in the *BMC International Health and Human Rights* article,[28] but elsewhere.[29] The remainder of the chapter will hence focus on the

26 Brolan et al. (2015).

27 Forty interviews were held in June-July 2013; 33 face-to-face interviews and seven by Skype with 57 participants, and two additional participants provided email responses. Participants were from a total of 31 agencies: 17 multilaterals, four academic institutes, three foundations, three non-government organisations (NGOs), two government agencies, and two development banks. In the second interview round held almost 12 months later in April-May 2014, the research team narrowed the second round interview question guide and participant sample; only interviewing participants working exclusively on the post-2015 health and development agenda in health related multilaterals or Global Health initiatives, and specialists from NGOs and academic institutes. Second round interviews comprised 14 face-to-face semi-structured interviews with 18 participants from a total of eight agencies (five multilaterals, two academics and one foundation). Nine participants had been interviewed in the first round.

28 Brolan et al. (2015).

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six cumulative reasons given by the high-level study participants as to why the right to health, in their view, lay at the periphery of post-2015 health goal negotiations.

3.1 Reason 1: The Right to Health is on the Fringes of High-Level Post-2015 Health and Development Negotiation

Key informants highlighted that, in short, the right to health (in its express form) was on the sidelines of post-2015 health and development negotiations; especially high-level discussion between the UN and member states. The right to health's lack of prominence on the post-2015 negotiation radar is reinforced by its lack of visibility in the key post-2015 reports that emerged in 2013 and 2014, which put forth to the global community potential health and sustainable development goals (and targets) for in-depth discussion. The marginalisation of the right to health in these formative reports is evidenced in our overview of the same above in Section 2.

3.2 Reason 2: The Right to Health's Sidelining is Part of a Broader Human Rights Marginalisation

Participants, however, considered the right to health was not alone being singled out and marginalised by high-level actors in emergent post-2015 global health dialogue. Rather, many key informants were of the view the right to health's relegation was part of the broader sidelining of human rights in wider post-2015 discussions. In fact, some key informants perceived human rights a potential and very real »fault line« to UN member state decision-making consensus on the SDG metrics. Therefore, many felt »pragmatics« would »prevail«. That is, that explicit inclusion of human rights would be effectively forfeited by governments worldwide so as to ensure the General Assembly could reach a collective decision on the post-2015 goal framework.

Alternatively, some key informants considered that should human rights rhetoric indeed prevail in the final post-2015 SDGs, then this would be be-

29 Brolan/Hill (2014).

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cause UN member states had »compromised« on a post-2015 SDG framework that was weak or, in the words of one participant, »watered down«; or that the UN member states had opted for symbolism over much needed action. Most participants, however, considered human rights inclusion wholly unlikely. Several reasoned this was due to the alignment of an alliance of otherwise heterogeneous member states with a cultural relativist argument against human rights, related to deep and divisive geopolitical power-plays. As one key-informant stated:

»Some nations […] are allergic to the term ›human rights‹. They feel […] it is the Western countries beating them around the head trying to impose Western cultures on them.«

3.3 Reason 3: Member State Anxiety Around Potential Inclusion of SRHR

In both interview rounds in 2013 and 2014, key informants were concerned that SRHR, as an express matter of *rights*, was in and of itself another very real »fault line« to post-2015 SDG decision-making consensus among member states. Indeed, this was *in addition* to »human rights« being perceived as a »fault line« threatening member state decision-making consensus. In the first interview round in mid-2013, participants predicted »an almighty fight« would likely arise over SRHR's incorporation in the post-2015 SDG metrics framework. These participants anticipated this »fight« against SRHR's inclusion would be led by strong Catholic and Islamic nations.

However, when the second round of interviews were conducted almost one year later in April-May 2014, the discourse around SRHR had substantially migrated. By 2014, key informants now spoke of their concern that SRHR were being increasingly connected by countries to debate around post-2015 lesbian, gay, bi-sexual, transgender, queer and inter-sex (LGBTQI) rights. For these participants, government linkage of SRHR with advancement of LGBTQI rights only made the argument for SRHR's inclusion in the post-2015 SDGs, as one participant explained, »more and more difficult«. This seems to be the origins of the splitting of SRHR into Sexual and Reproductive Health and Reproductive Health Rights in the final SDG 5.6 wording, retaining reference to Reproductive Rights while precluding

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the inclusion of Sexual Rights and their potential to provide a platform for further, more inclusive, redefinition. Yet one participant from a UN agency suggested unfolding arguments for and against SRHR's inclusion among member states were not actually, at a de facto level, about sexual and reproductive health as a matter of rights. In this participant's view, this point of contention could not (again) be divorced from larger, deep-seated geopolitical power-plays:

»It's mostly a power play between the North and South, if I can put it crudely. For instance, the African Group has gone very conservative and that might be the use of SRHR as a bargaining chip within the North/South debates […].«

3.4 Reason 4: An Overarching Post-2015 Right to Health Goal is too Big to be Defined

Despite a handful of participants acknowledging the right to health is articulated in Article 12 of the ICESCR, from immersion in the data it became clear that this definition of the right to health was unknown by a sizeable cluster of key informants. Many participants were vague with regards to the meaning of the right to health, and the source of this meaning; a number considered the »aspirational« right to health to be a »fuzzy«, broad imperative that was »too big« to be pragmatically condensed into a single, overarching post-2015 global health goal. Many considered that confusion around the right to health's definition was subsequently a key reason that precluded a serious and focused discussion on the right to health's potential to translate into the headline post-2015 health and development goal among the UN member states.

3.5 Reason 5: Even If a Headline Right to Health Goal is Coherently Defined, it is too Difficult to Implement

Participants in the second interview round were particularly emphatic that even if the right to health could be translated cogently into the post-2015 health and development goal, its broad elements were nonetheless too difficult to implement, to »measure«. This concern was best captured in the following statement by one participant:

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»For me, it's a very good principle, the right to health, but we need to materialise [it], really carry it out, how it spells out in different programs and different indicators. Because […] it's very hard to conceptualise what exactly we should do to get there. […] So people really want targets […] if we don't have a target how do we manage our program?«

3.6 Reason 6: The Right to Health would be Implicitly Captured in a Post-2015 Health and Development Goal

Paradoxically, while many participants were unable to identify what the right to health's content included per Article 12 of the ICESCR, they nonetheless associated the aspirational nature of the right to health with the more tangible concepts of Universal Health Coverage, or health equity, or a ›Healthy Lives across the Life Course‹ approach. And, what is more, all three concepts appeared to obtain more discursive coverage in the post-2015 global health and development goal debate than the prima facie right to health in international law. In fact, seven participants in the second interview round viewed Universal Health Coverage as the tangible expression of the right to health, while others spoke of how the right to health would be inherently represented in the final health goal framework if words such as »equity« or »equality« were inserted into the text of the final SDG metrics:

»When you unpack equity […] you're talking about everyone having a right […] it's often a presentation thing rather than a principle thing if you like.«
»The right to health, as far as I can see – it all seems to come down to how you address the inequalities in health in the world.«

4. REFLECTION

As noted at the beginning of this Chapter, the final SDG framework was voted on by the UN General Assembly in September 2015. And, as has been further contended, the right to health in its express form did not translate into the overarching post-2015 health and development goal, nor explicitly appear in the content of this goal's nine targets and four means of implementation (Figure 2). Through reviewing the six reasons given by this study's key informants as to why the right to health seemed to be on the

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fringes of evolving post-2015 health goal negotiations, the marginal presence of the right to health in the final post-2015 outcome document is unsurprising; and certainly anticipated by the majority of this study's participants. Moreover, participants' general prediction that broader human rights would likely be kept separate from final SDG metrics, in the interests of UN member state decision-making consensus, materialised. Thus, while the SDG framework that finally emerged was indeed a most broad and comprehensive plan of action for »people, planet and prosperity«,[30] it appears this was at the expense of the member states affirming human rights' rich and intrinsic connect with development.[31]

It is therefore submitted that through the post-2015 SDGs of September 2015, the UN member states have perpetuated the schismatic relationship between international human rights law *and* global development policy and planning, which had been progressed in 2001 by the SDGs predecessor, the MDGs.[32] Indeed, the high-level technocrats responsible for configuring the eight MDGs in the spring and summer of 2001 have been most forthright that rights and measureable goals and targets were not to intermingle; in their view, »development« and »rights« were incompatible.[33] According to Jan Vandemoortele who was tasked by UN Secretary-General Kofi Annan to lead the small interagency team to devise those goals:

»The [MDGs] express targets that are feasible at the global level. They should not be seen as a normative statement of what is desirable in an ideal world, which is already embedded in the various human rights treaties that have been ratified by member states to varying degrees. There is no need to repeat or overlap with these instruments.«[34]

As a number of participants in our study advised, and as with the MDG formulation process, metrics mattered foremost in post-2015 high-level negotiations (in addition to politics!). Thus if the respective post-2015 health goal and/or target being advocated for inclusion could be pragmatically de-

30 A/Res/70/1, 25 September 2015.

31 Alston (2005); Darrow (2012).

32 Alston (2005).

33 Murphy (2012).

34 Vandemoortele (2011), 14.

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fined, dissected and measured ideally through quantitative means, then it stood good chance of at least vying for member state attention in post-2015 negotiations. And, if the conceptual framing stood good chance of attracting member state (as well as multilateral and other) attention and discourse, then it stood some chance of being up-taken and included in the final post-2015 health goal framework. Following this line of reasoning, it is of little wonder that during the recent post-2015 SDG formulation period the World Health Organization, in partnership with the World Bank, was ensconced in demonstrating how Universal Health Coverage could be measured at a country and global level.[35]

Nevertheless, it follows that this finding above points to a number of larger challenges for right to health advocates moving forward. The first is *that even if* the right to health had been successfully quantified and pitched to the post-2015 decision-makers, the conglomerate of member states, this still might not have been enough to ensure member state inclusion of the right to health expressly in the post-2015 health and development goal framework. This is because, as anticipated by the findings in our study, participants generally perceived it unlikely that a broader human rights agenda would be incorporated in post-2015 SDG metrics. Therefore, even if the right to health in its explicit form had been successfully repackaged and advocated to member states as a potential *measurable* goal and/or target, it would nonetheless arguably have been sacrificed in member states' broader sidelining of human rights language (and thus a human rights agenda) in the SDG goals, targets and indicators.

The second challenge for right to health advocates arising from this study is that it appears many high-level personnel in influential global health policy roles (and health and development policy roles more broadly), might not actually understand what the right to health *means* or, in other words, how the right to health is defined in international human rights law. It follows an array of these individuals (at least in our study) were uncomfortable with outright support of an explicit post-2015 right to health goal, and certainly not with lending such support directly on behalf of their respective organizations. However, this conservatism is inherently tied to the perceptible lack of prima facie knowledge among this study's key informants on *what* the right to health in fact is; and thus *why* its express incorpo-

35 WHO/World Bank (2014) and (2015).

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ration in the new development goal framework truly matters. In the view of many participants in our study, whatever the content of the right to health might be, it is for them aspirational and not pragmatically or tangibly applicable, nor measurable or politically palatable, so as to warrant prominence in the metrics of this formative global health policy endeavour.

Here, it is timely to remind why the right to health's incorporation in the post-2015 health goal framework is important. Among the mix of reasons, three will be highlighted. First, the right to health underpins global development policy, planning and implementation with a normative basis, allowing development to become a process by which *people* can progressively realise their human rights. Second, the right to health in international law, although not without its sceptics,[36] *is* the normative gold standard for global health that *all* UN member states have adopted (in some form) to respect, protect and fulfil.[37] Third, if the post-2015 health goal is to have any bite, it needs *legal* teeth: »Rights remove discretion from development and provide a framework of accountability«.[38] Thus progressive and contextual achievement of the health SDG's content by the international community of states (and their array of partners) between 2016 and 2030 should not be based solely on state commitments engendered by a post-2015 global health policy. Rather, UN member state commitment must be combined with states' obligations under international human rights law, and the consequential government accountability mechanisms and legal remedies that surround this.[39]

4.1 Refocusing and Moving Forward in 2017 and Beyond

Right to health advocates must return to the words of Jonathan Mann, the founder of the modern health and human rights movement,[40] in their reflection on the liminal presence of the right to health in the post-2015 health goal framework:

36 Baumrin (2012).

37 Backman et al. (2008); Kinney/Clark (2004); Perehudoff (2008).

38 Sidibe/Buse (2013).

39 Yamin (2008).

40 Tarantola et al. (2006).

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»[…] Similarly, contemporary human rights, seeking to understand how to advance human well-being in diverse real-life settings, needs to draw upon a more sophisticated understanding of health, health status, and health realities […]. Action is liberating: it can teach what cannot be learned nor imagined in the abstract. As much as we believe in the power of rhetoric […] we need to see how and to what extent realising human rights and increasing respect for dignity can operate to diminish the societal contribution to disease, disability and death. While this work can draw upon traditional and well-developed modes of public health and human rights work, it will require innovation, experiment, and risk-taking.«[41]

To this end, »the innovation, experiment, and risk-taking« must occur in multiple ways if it is to progress the right to health as »value added«[42] in the global health and development policy-making landscape.

Firstly, it is recommended that a serious conversation begins involving not only right to health advocates, but inter-sectoral human rights advocates, equally disappointed with the disconnect between human rights and the final post-2015 SDG metrics. This is because an urgent discussion must be initiated around how the bridge can be more effectively built between human rights and development in the post-2015 world. Insight from right to development advocates also needs to be elicited in this discussion. A conference or meeting of sorts might be a good starting point in facilitating such discourse.

Secondly, if the onus in contemporary, high-level development policy and planning is ›all about the numbers‹ and results based management, then right to health advocates need to strategically ›play the game‹. Certainly, political realists would support this notion. It is therefore recommended right to health advocates consider how to insert more of the normative into the empirical, and more of the empirical into the normative. Working in partnership with communities, civil society, policy-makers, and global health colleagues from different disciplinary backgrounds, a flexible coherent framework with corresponding measures and targets for implementation for the right to health as espoused in international human rights law – particularly as elucidated and framed by the UN Committee on Economic, Social and Cultural Rights in its General Comment No. 14 of 2000 – could be

41 Mann (1997), 118–119.

42 Darrow (2012).

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developed. In collaboratively configuring such a tool, the right to health's content need not be detracted from or compromised. Here, right to health advocates can draw inspiration from related and already-developed scientifically-informed matrixes such as the EquiFrame.[43] On this point, it is further recommended that right to health country-reporting matrixes are then linked to states' reporting obligations on the right to health with regards to UN treaty documents. In this way, the one innovative matrix (and its data) can be used by governments to serve two significant reporting purposes.

Thirdly, while a number of scholars from various disciplines consider the tension between cultural relativism and human rights an old and irrelevant debate, the findings from our study suggest otherwise. Indeed, our research indicates this tension remains an ongoing and real point of contention influencing and impacting member state decision-making consensus in the development field. Hence part of the serious conversation that must be had around the disconnect of the right to health from the post-2015 metrics framework, needs to examine this point. Health policy and related practitioners, especially in developing countries, are familiar with cultural relativist critique and related claims for regional exceptionalism:[44] universality-relativist tension emerges in a range of health issues particularly relating to women's and girls' health, and the health of LGBTQI individuals and communities.[45]

Finally, right to health advocates need to work hard in a plethora of forums, explaining in plain, simple, and persuasive language what the right to health is and why and how this human right (as with all human rights) are necessarily part of sustainable development, and should therefore be clearly linked as such to development metrics. Of course, such efforts would be assisted if a right to health reporting matrix or measurement tool can be pointed to.

The four tasks identified above are enormous. At their heart, they implicate several paradigm shifts. One of these shifts involves repeatedly exposing those in elite positions who make decisions in the global health policy landscape, and who are frequently trained and educated in approaching that landscape through bio-medical and/or quantitative scientific methods

43 Amin et al. (2011).

44 Kirby (2011).

45 Murphy (2012); Tong (2012).

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and/or through an economic (neo-liberal) lens, to reframe their wholesale response to global health challenges by applying (and prioritising) normative health and human rights law. While human rights is not the only framing for the complex that is global health and foreign policy,[46] more work needs to be invested in having human rights law not only merely understood and acknowledged, *but prioritised* by our rich diversity of global health and development peers. Of course, this fundamental reframing of what must be prioritised and respected in global health and development policy — that is, international human rights law, and member states obligations toward the same — must also be a message facilitated in tertiary educational settings, and especially directed toward public health, global health, international public health, public policy and social policy, and international development graduates.

Of course, the task before right to health advocates (who are in no way homogenous in their outlook and interpretation of the right to health), seems all too overwhelming: a lifetime of work is clearly on the horizon. However, commitment to the right to health vocation finds home in the words of Jonathan Mann:

»The health and human rights linkage, as seen from the public health side […] provides a better guide for identifying, analysing and responding directly to critical societal conditions than any framework inherited from the biomedical or recent public health tradition. Thus, promoting and protecting health is proposed to depend upon the promotion and protection of human rights and dignity. The consequences of this line of thinking are nothing short of revolutionary for public health practice […]. We share a confidence in the future – and in our ability to contribute – each in our own ways and yet together to the healing of the world […]. This is our modesty, also our boldness, also our aspiration – and together we form a multitude.«[47]

And, in working to slowly but incrementally achieve the above, Mann further cautions us to be reflexive, collegial and collaborative in so doing:

46 Labonte/Gagnon (2010); Stuckler/McKee (2008).

47 Mann (1997), 114 and 120.

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»Avoid creating, inadvertently, an oppressive orthodoxy […]. The fields of public health and human rights can learn much from each other […]. A multiplicity of approaches, selected and designed locally by people directly concerned, is best.«[48]

Mann's above words were published in 1997. Twenty-years on, and in light of the side-lining of the right to health and international human rights law from the final post-2015 global health and development goal metrics, there is considerable work to be done by right to health advocates. We must continue to let Mann's words guide and inspire us.

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48 Ibid., 116–118.

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